DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To: Resource Based Relative Value Scale (RBRVS) Users:
- Anesthesiologists
- Advanced Registered Nurse Practitioners (ARNPs)
- Blood Banks
- Emergency Physicians
- Family Planning Clinics
- Federally Qualified Health Centers
- Health Departments
- Laboratories
- Managed Care Organizations
- Nurse Anesthetists
- Ophthalmologists
- Physicians
- Physician Clinics
- Podiatrists
- Psychiatrists
- Radiologists
- Registered Nurse First Assistants

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For information, contact Provider Relations at: 800.562.3022 or http://maa.dshs.wa.gov/contact/prucontact.asp

Supersedes: # Memo 02-61 MAA

From: Douglas Porter, Assistant Secretary
Health and Recovery Services Administration (HRSA)

Subject: **Physician-Related Services: 2007 Changes and Additions to CPT® and HCPCS Codes, Policies and Fee Schedules**

Effective for dates of service on and after January 1, 2007, unless otherwise specified, the Health and Recovery Services Administration (HRSA) will:

- Begin using the Year 2007 Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding System (HCPCS) Level II code additions as discussed in this memorandum;
- Update the Physician-Related Services Fee Schedule to include the new 2007 codes, fees, and base anesthesia units (BAU); and
- Update and clarify various policies and payment rates.

Overview

- **All policies previously published remain the same unless specifically identified as changed in this memo.**

- Do not use CPT and HCPCS codes that are deleted in the "*Year 2007 CPT*" book and the "*Year 2007 HCPCS*" book for dates of service after December 31, 2006.

Fee Schedule

- You may view HRSA's Physician-Related Services Fee Schedule on-line at http://maa.dshs.wa.gov/RBRVS/Index.html

- For a paper copy of the fee schedule, see "How can I get HRSA's provider documents?" on the last page of this memorandum.

Bill HRSA your usual and customary charge.

Maximum Allowable Fees and BAU

HRSA used the following resources in determining the maximum allowable fees and BAU for the Year 2007 additions:

- Year 2007 Medicare Physician Fee Schedule Data Base (MPFSDB) relative value units;

- Year 2007 Medicare Laboratory Fee Schedule; and

- Current Conversion Factors.

> **Note:** Due to its licensing agreement with the American Medical Association regarding the use of CPT codes and descriptions, HRSA publishes only the official brief description for all codes. Please refer to your current CPT book for full descriptions.

New and Deleted 2007 HCPCS Modifiers

Please review the 2007 HCPCS book for those modifiers that have been added or deleted for the current year. HRSA accepts all modifiers as informational only. Modifier descriptions may be viewed in the 2007 HCPCS book. HRSA may require inclusion of some of the modifiers for payment purposes. HRSA will notify you in future memorandums when a modifier is required for payment purposes.

Deleted CPT and HCPCS Codes

HRSA has incorporated the CPT and HCPCS code updates into the January 1, 2007, Physician Related Services Fee Schedule. HRSA has updated coverage, prior authorization, Centers of Excellence, and fees.

Prior Authorization Update

The following CPT and HCPCS codes require some type of authorization, either Prior Authorization (PA) or Expedited Prior Authorization (EPA). The list below includes both new 2007 codes and existing codes with authorization requirement changes:

0162T	33254	76814	94775
0166T	33255	77058	94776
0174T	33256	77059	94777
0175T	33265	77371	J0129
15830	33266	77372	J0364
17315	37210	77373	L8690
19300	43647	77435	L8691
21248	43648	83913	L8695
21249	43881	92025	Q4082
22526	43882	92640	S0147
22527	58548	94774	S2325

For Details on HRSA's PA process, refer to the Authorization section (Section I) of HRSA's current *Physician-Related Billing Instructions.*

Prior Authorization Changes

The following procedure codes no longer require PA or EPA:

32855	85055	88334	J7340	J7343
32856	85396	88342	J7341	J7344
33944	88333	88346	J7342	

Coverage changes

- HRSA has changed the following code from **noncovered to covered**:

Procedure Code	Brief Description
96119	Neuropsych testing by tec

- HRSA has changed the following codes from **noncovered to covered** for Children's Hospital and Regional Medical Center, Seattle, only for small bowel transplants:

Procedure Code	Brief Description
44135	Intestine transplant-cadaver
44136	Intestine transplant-live

- HRSA has changed the following codes from **covered to noncovered**:

Procedure code	Brief Description
S0138	Finasteride, 5 mg
S0141	Zalcitabine, 0.375 mg

Prior Authorization Requirement Correction

Retroactive to dates of service on and after July 1, 2006, CPT codes 88384, 88385, and 88386 do not require PA. In the July 1, 2006, Physician-Related Services Fee Schedule, HRSA incorrectly listed these codes as requiring PA.

Policy Update for HCPCS Code L9900

HRSA requires an invoice for HCPCS code L9900 ***regardless of billed charges***. HRSA denies claims without this invoice.

Expedited Prior Authorization Changes

The procedure code for mastectomy for gynecomastia (CPT code 19140) has been deleted and replaced by CPT code 19300. HRSA has updated the EPA criteria for this code to reflect this change (see below).

Reduction Mammoplasties/Mastectomy for Gynecomastia
CPT: 19318, 19300
DX: 611.1 and 611.9 only

242 Diagnosis for ***gynecomastia***:

1) Pictures in clients' chart, *and*
2) Persistent tenderness and pain, *and*
3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.

250 Reduction mammoplasty or mastectomy, not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.

Immunization Changes and Updates

HRSA no longer requires PA for CPT code 90734 (Meningococcal vaccine, im) for those clients **18 years of age and younger**. This vaccine is available at no charge from the Department of Health (DOH). For those clients 19 years of age and older, HRSA **still requires EPA** for CPT code 90734.

Retroactive to dates of services on and after July 5, 2006, Boostrix (CPT code 90715) is available at no charge from the Department of Health (DOH).

Retroactive to November 1, 2006, HRSA will pay for CPT code 90680 (Rotovirus vacc 3 dose, oral) for children under 32 weeks of age. HRSA will pay for both FFS and HO clients. This vaccine will not be available free-of-charge from DOH. Providers must bill acquisition cost and may bill for the administration of the vaccine.

Procedure Code	Brief Description	January 1, 2007 Maximum Allowable Fee
90680	Rotovirus vacc 3 dose, oral	A.C

If an immunization is the only service provided, bill only for the administration of the vaccine and the vaccine itself (if appropriate). Do not bill an E&M code unless a significant and separately identifiable condition exists and is reflected by the diagnosis. In this case, bill the E&M code with modifier 25. If you bill the E&M code on the same date of service as a vaccine administration without modifier 25, HRSA will deny the E&M code. **Exception**: If an immunization is the only service provided (e.g., immunization only clinic) and a brief history of the client must be obtained prior to the administration of the vaccine, you may bill 99211 with modifier 25. The brief history must be documented in the client record.

> **Note**: The above policy **does not** apply to E&M CPT codes 99381-99385, 99391-99395 used for EPSDT screening visits. HRSA will reimburse these procedure codes with the administration of the vaccine and the vaccine itself (if appropriate) without requiring a modifier 25 to be appended to the E&M.

Reminder:

- When billing HRSA for an immunization that is available free-of-charge from DOH, you must include both of the following:

  ✓ The appropriate procedure code for the vaccine given; and
  ✓ The SL modifier (**For example:** 90707 SL).

  HRSA pays $5.96 for the SL modifier billed with vaccines obtained free-of-charge from DOH.

- HRSA pays for nasal Flu vaccines (CPT 90660) from October 1-March 31 of each year.

Hyalgan/Synvisc

- HRSA reimburses only orthopedic surgeons, rheumatologists, and physiatrists for Hyalgan or Synvisc.

- HRSA allows a maximum of 5 Hyalgan or 3 Synvisc intra-articular injections **per knee** for the treatment of pain in osteoarthritis of the knee. Identify the left knee or the right knee by adding the modifier LT or RT to your claim.

- This series of injections may be repeated at 12-week intervals.

- Providers must bill for Hyalgan and Synvisc using the following HCPCS codes:

HCPCS Code	Description	Limitations
Q4083	Hyalgan or Supartz, inj	Maximum of 5 injections Maximum of 5 units (1 unit = 1 injection of 20-25 mg)
Q4084	Synvisc, inj	Maximum of 3 injections Maximum of 3 units (1 unit = 1 injection of 16 mg)

- Hyalgan and Synvisc injections are covered for treatment of osteoarthritis of the knee only with the following ICD-9-CM diagnosis codes:

Diagnosis Code	Description
715.16	Osteoarthritis, localized, primary lower leg.
715.26	Osteoarthritis, localized, secondary, lower leg.
715.36	Osteoarthritis, localized, not specified whether primary or secondary, lower leg.
715.96	Osteoarthritis, unspecified whether generalized or localized, lower leg.

- The injectable drugs must be billed after all injections are completed.

- Bill CPT injection code 20610 each time an injection is given, up to a maximum of 5 injections for Hyalgan or 3 injections for Synvisc.

You must bill both the injection CPT code and HCPCS drug code on the same claim form.

Note: HRSA does ***not*** pay for Hyalgan and Synvisc injections when billed with HCPCS codes Q4085 and Q4086.

Ventilator Management

CPT codes 94656 and 94657 have been deleted and replaced by CPT codes 94002-94004. Do not bill an E&M code unless a significant and separately identifiable condition exists and is reflected by the diagnosis. In this case, bill the E&M code with modifier 25. If you do not use modifier 25, HRSA will deny the E&M code.

Ultrasound Screening for Abdominal Aortic Aneurysm
(HCPCS procedure code G0389)

HRSA covers this screening only when:

- Billed with diagnosis code V81.2 (special screening for other and unspecified cardiovascular conditions); and

- A client meets at least one of the following conditions:

  - ✓ Has a family history of an abdominal aortic aneurysm; or
  - ✓ Is a male who is 65-75 years of age and has smoked at least 100 cigarettes in his lifetime.

Vivitrol

HRSA only pays for Vivitrol when billed by a pharmacy through the Point-of Sale (POS) system.

Breast Surgeries

HRSA has updated the list of covered procedure codes for breast surgeries with the new 2007 CPT codes. The policy reads as follows:

> HRSA pays for the following procedure codes, which include breast removal and breast reconstruction, for clients who have breast cancer or a history of breast cancer, burns, open wound injuries, or congenital anomalies of the breast. When billing, you must use the following list of diagnosis codes; **otherwise, HRSA requires PA**. HRSA pays for the removal of failed breast implants only if you bill with ICD-9-CM diagnosis code 996.54. This service requires PA. HRSA will pay to remove breast implants but will not replace them if they were placed for cosmetic reasons.

CPT Code(s)	Description	Limitations
11960	Insertion of tissue expander(s)	Limited to ICD-9-CM diagnoses: ✓ V10.3 ✓ 174.0-175.9 ✓ 757.6 ✓ 759.9 ✓ 879.0-879.1 ✓ 906.0 ✓ 906.8 ✓ 942.00-942.59
11970	Replace tissue expander	
11971	Remove tissue expander(s)	
*19301	Removal of breast tissue	
*19302	Remove breast tissue, nodes	
*19303	Removal of breast	
*19304	Removal of breast	
*19305	Mast, radical	
*19306	Mast, rad, urban type	
*19307	Mast, mod rad	
19316	Suspension of breast	
19340	Immediate breast prosthesis	
19342	Delayed breast prosthesis	
19350	Breast reconstruction	
19357	Breast reconstruction	
19361	Breast reconstruction	
19364	Breast reconstruction	
19366	Breast reconstruction	
19367	Breast reconstruction	
19368	Breast reconstruction	
19369	Breast reconstruction	
19370	Surgery of breast capsule	
19371	Removal of breast capsule	
19380	Revise breast reconstruction	

*Denotes added codes

Injectable Drug Updates

HRSA updates, on a quarterly basis, the maximum allowable fees for drugs administered in a kidney center. **These quarterly drug updates are posted online only.** For current Injectable Drug Updates, visit HRSA on the web at: http://maa.dshs.wa.gov. Click ***Provider Publications/Fee Schedules,*** then ***Accept***, then ***Fee Schedules****;* then click the file with the most current date under the heading **Injectable Drugs**.

Blood Bank Services

The following bank HCPCS codes are now reimbursed at Acquisition Cost (AC).

Procedure Code	Brief Description
J7187	Inj Vonwillebrand factor IU
J7188	Inj Von Willebrand factor IU
J7189	Factor VIIa
J7190	Factor VIII
J7191	Factor VIII (porcine)
J7192	Factor VIII recombinant
J7193	Factor IX non-recombinant
J7194	Factor IX complex
J7195	Factor IX recombinant
J7197	Antithrombin III injection
J7198	Anti-inhibitor

Laboratory

New Laboratory STAT codes

The following CPT codes have been added to the list of STAT lab charges that HRSA allows to be performed on a STAT basis: 83664, 85025, and 86367.

Clinical Laboratory Codes

Some clinical laboratory codes have both a professional component and a technical component. If performing only the technical component, do not bill with a modifier. The professional component for physician interpretation must be billed using modifier 26. Laboratories performing both the professional and the technical components must bill the code without a modifier for the technical and with modifier 26 for the professional. These services may be billed either on separate lines or on separate claim forms. Refer to the table below for those codes with both a technical and professional component.

The following codes are clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the laboratory fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense.

83020	84181	86255	86327	87207
83912	84182	86256	86334	88371
84165	85390	86320	86335	88372
84166	85576	86325	87164	89060

Laboratory codes requiring modifier and prior authorization clarification

Laboratory claims must include an appropriate medical diagnosis code, modifier, and PA, if applicable. The ordering provider must give the appropriate medical diagnosis code, modifier, and PA number, if applicable, to the performing laboratory at the time the tests are ordered. HRSA does not pay for laboratory procedures billed using ICD-9-CM diagnosis code V72.6 as the primary diagnosis.

Cancer Screens

Procedure code G0107 has been deleted and replaced with procedure code 82270. HRSA has updated the list of diagnoses that are payable when billing for HCPCS code G0105. Please review the updated table below:

HCPCS Code	Limitations	Payable Only With Diagnosis Code(s)
G0105	Clients at high risk for colorectal cancer One every 24 months Must use modifier 53 if procedure is discontinued.	High risk 555.1, 555.0, 555.2, 555.9, 556.0-556.6, 556.8, 556.9, 558.2, 558.9, V10.05, V10.06, V12.72, *V18.51, V84.09, or V16.0.
82270	Clients age 50 and older Once every 12 months (1-3 simultaneous determinations)	Any valid ICD-9-CM code other than high risk (e.g., V76.51)

*Denotes added diagnosis code

Procedure codes for screening mammograms (CPT codes 76092 and 76083) have been deleted. The new CPT procedure codes are 77052 and 77057.

HRSA has adopted the National Cancer Institute (NCI) recommendations regarding screening mammograms (CPT code 77052 and 77057). For clients age 40 and over, HRSA allows one annual screening mammogram per calendar year. HRSA requires PA for screening mammograms for clients 39 years of age and younger.

> **Note:** HRSA does not pay for HCPCS code G0394 for colorectal cancer screening. When billing for this service, you must use CPT code 82270.

Outpatient Cardiac Rehabilitation (CPT code 93798)

HRSA has updated the list of appropriate diagnoses for outpatient cardiac rehabilitation by including the 5th digit for ICD-9-CM diagnosis codes 410.00-410.92 for acute myocardial infarction.

Centers of Excellence (COE) Policy Update

HRSA has updated policy relating to approved Centers of Excellence (COE) (see below).

The following services must be performed in an HRSA-approved COE and **do not require prior authorization:**

> **Note:** As required by federal law, organ transplants and services related to an organ transplant procedure are not covered under the AEM program.

- Organ/bone marrow/peripheral stem cell transplants. HRSA pays for organ procurement fees and donor searches. HRSA pays for the first 15 donor searches (CPT codes 86812-86822) for bone marrow or peripheral stem cell transplants without prior authorization. Donor searches in excess of 15 searches require prior authorization. When billing for these donor services, you must use the recipient's PIC code;

- Inpatient Chronic Pain Management; or

- Sleep studies (CPT codes 95805, 95807-95811) are allowed for the following ICD-9-CM diagnoses only:

327.10	327.20	327.27	780.51
327.11	327.21	327.42	780.53
327.12	327.23	327.51	780.54
327.14	327.26	347.00-347.11	780.57

> **Note:** When billing on a paper 1500 claim form, note the COE provider number in field 32. When billing electronically, note the COE provider number in the *Comments* section.

Bariatric Surgery

Bariatric surgeries must be performed in an HRSA-approved hospital and **require prior authorization**.

HRSA covers medically necessary bariatric surgery in an HRSA-approved hospital with a bariatric surgery program in accordance with WAC 388-531-1600. PA is required. To begin the authorization process, fax a completed Bariatric Surgery Request form [DSHS # 13-785] to:

HRSA
Attn: Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
FAX: 360.586.1471

Clients enrolled in Healthy Options are eligible for pre-authorized bariatric surgery under HRSA's fee-for-service program. Clients enrolled in Healthy Options who have complications following an HRSA-approved bariatric surgery are covered fee-for-service for these complications up to 365 days from the date of the surgery. HRSA requires authorization for payment of these services due to complications.

Psychiatric Services

HRSA pays for procedure codes 99241-99245 with all HRSA-covered diagnoses codes for psychiatric services.

Implanon (CPT code S0180)

HRSA pays for the contraceptive implant system, Implanon.

To bill for Implanon, providers must:

- Bill with ICD-9 Diagnosis V25.5;
- Use CPT procedure code 11981 with ICD-9 diagnosis code V25.5 for the insertion of the device;
- Use CPT procedure code 11982 with ICD-9 diagnosis code V25.43 for the removal of the device;
- Use CPT procedure code 11983 with ICD-9 diagnosis code V25.43 to remove the device with reinsertion on the same day; and
- Enter the NDC in Box 19 on the 1500 Claim Form and send in an invoice with your billing.

Note: HRSA pays for Implanon only once every three years, per client.

PET Scan Update

HRSA has updated the following PET scan fees retroactive to July 1, 2006. If you have submitted claims with dates of service on and after July 1, 2006, do not rebill them. HRSA will do a mass adjustment.

Procedure Code	Modifier	July 1, 2006 Maximum NFS Fee	July 1, 2006 Maximum FS Fee
78459	26	$48.84	$48.84
78459	TC	1,165.94	1,165.94
78459		1,214.78	1,214.78
78608	26	47.69	47.69
78608	TC	1,165.94	1,165.94
78608		1,213.63	1,213.63
78811	26	49.99	49.99
78811	TC	1,165.94	1,165.94
78811		1,215.93	1,215.93
78812	26	61.91	61.91
78812	TC	1,165.94	1,165.94
78812		1,227.85	1,227.85
78813	26	64.20	64.20
78813	TC	1,165.94	1,165.94
78813		1,230.14	1,230.14
78814	26	$70.62	$70.62
78814	TC	1,165.94	1,165.94
78814		1,236.56	1,236.56
78815	26	77.96	77.96
78815	TC	1,165.94	1,165.94
78815		1,243.90	1,243.90
78816	26	79.80	79.80
78816	TC	1,165.94	1,165.94
78816		1,245.74	1,245.74

Note: All Pet Scans require Prior Authorization

Organ Transplants

HRSA updated the organ transplant table for those facilities that are approved to do transplants to include both the transplant itself and the donor. Providers must use the recipient's PIC number to bill for donor services.

Approved Transplant Hospitals	Organ(s)	CPT Codes
Children's Hospital & Regional Medical Center/Seattle	Bone Marrow (BMT) (autologous & allogenic)	• Transplant: ✓ 38240 or 38241 • Donor: ✓ 38230
	Peripheral Stem Cell Transplant (PSC-T)	• Transplant: ✓ 38240, 38241, or 38242 • Donor: ✓ 38205 or 38206
	Heart	• Transplant: ✓ 33945 • Prepare Organ: ✓ 33944 • Donor: ✓ 33940
	Liver	• Transplant: ✓ 47135 or 47136 • Prepare Organ: ✓ 47143, 47144, or 47145; and ✓ 47146, 47147 • Donor: ✓ 47133, 47140, 47141, or 47142
	Kidney	• Transplant: ✓ 50360 or ✓ 50365 and 50380 • Prepare Organ: ✓ 50323 or ✓ 50325; and 50327-50329 • Donor: ✓ 50300, 50320, or 50547
	Small Bowel	• Transplant: ✓ 44135 or 44136 • Prepare Organ: ✓ 44715 and ✓ 44720, 44721 • Donor: ✓ 44132 or 44133

Approved Transplant Hospitals	Organ(s)	CPT Codes
Doernbecher Children's Hospital/Portland NW Marrow Transplant Program (PSC-T only)	BMT	• Transplant: ✓ 38240 or 38241 • Donor: ✓ 38230
	PSC-T	• Transplant: ✓ 38240, 38241, or 38242 • Donor: ✓ 38205 or 38206
Good Samaritan Hospital/ Puyallup	PSC-T	• Transplant: ✓ 38240, 38241, or 38242 • Donor: ✓ 38205 or 38206
Inland NW Blood Center Spokane	PSC-T	• Donor: ✓ 38205 or 38206
Legacy Good Samaritan Hospital and Medical Center/Portland (Northwest Marrow Transplant Program)	BMT	• Transplant: ✓ 38240 or 38241 • Donor: ✓ 38230
	PSC-T	• Transplant: ✓ 38240, 38241, or 38242 • Donor: ✓ 38205 or 38206
Mary Bridge Children's Hospital and Health Center/Tacoma	PSC-T (autologous only)	• Transplant: ✓ 38241 • Donor: ✓ 38206

Approved Transplant Hospitals	Organ(s)	CPT Codes
Oregon Health Sciences University (OHSU) and Hospital/Portland	BMT	• Transplant: ✓ 38240 or 38241 • Donor: ✓ 38230
	PSC-T	• Transplant: ✓ 38240, 38241, or 38242 • Donor: ✓ 38205 or 38206
	Heart	• Transplant: ✓ 33945 • Prepare Organ: ✓ 33944 • Donor: ✓ 33940
	Liver	• Transplant: ✓ 47135 or 47136 • Prepare Organ: ✓ 47143, 47144, or 47145; and ✓ 47146, 47147 • Donor: ✓ 47133, 47140, 47141, or 47142
	Kidney	• Transplant: ✓ 50360 or ✓ 50365 and 50380 • Prepare Organ: ✓ 50323 or ✓ 50325; and 50327-50329 • Donor: ✓ 50300, 50320, or 50547
	Pancreas	• Transplant: ✓ 48554 or 48160 • Prepare Organ: ✓ 48551 and 48552 • Donor: ✓ 48550

Approved Transplant Hospitals	Organ(s)	CPT Codes
Providence St. Peter Hospital/Olympia	PSC-T	• Transplant: ✓ 38240, 38241, or 38242 • Donor: ✓ 38205 or 38206
Sacred Heart Medical Center/Spokane	Kidney	• Transplant: ✓ 50360 or ✓ 50365 and 50380 • Prepare Organ: ✓ 50323 or ✓ 50325; and 50327-50329 • Donor: ✓ 50300, 50320, or 50547
	Heart	• Transplant: ✓ 33945 • Prepare Organ: ✓ 33944 • Donor: ✓ 33940
	Heart/Lung(s)	• Transplant: ✓ 33935 • Prepare Organ: ✓ 33933 • Donor: ✓ 33930
	Lung	• Transplant: ✓ 32851, 32852, 32853, or 32854 • Prepare Organ: ✓ 32855 or 32856 • Donor: ✓ 32850
	PSC-T	• Transplant: ✓ 38240, 38241, or 38242 • Donor: ✓ 38205 or 38206
Seattle Cancer Care Alliance/Seattle	BMT	• Transplant: ✓ 38240 or 38241 • Donor: ✓ 38230
	PSC-T	• Transplant: ✓ 38240, 38241, or 38242 • Donor: ✓ 38205 or 38206

Approved Transplant Hospitals	Organ(s)	CPT Codes
St. Joseph's Medical Center/Tacoma	BMT (autologous only)	• Transplant: ✓ 38241 • Donor: ✓ 38230
	PSC-T	• Transplant: ✓ 38240, 38241, or 38242 • Donor: ✓ 38205 or 38206
Swedish Medical Center, Seattle	PSC-T	• Transplant: ✓ 38240, 38241, or 38242 • Donor: ✓ 38205 or 38206
	Kidney	• Transplant: ✓ 50360 or ✓ 50365 and 50380 • Prepare Organ: ✓ 50323 or ✓ 50325; and 50327-50329 • Donor: ✓ 50300, 50320, or 50547

Approved Transplant Hospitals	Organ(s)	CPT Codes
University of Washington Medical Center Seattle	Kidney	• Transplant: ✓ 50360 or ✓ 50365 and 50380 • Prepare Organ: ✓ 50323 or ✓ 50325; and 50327-50329 • Donor: ✓ 50300, 50320, or 50547
	Heart	• Transplant: ✓ 33945 • Prepare Organ: ✓ 33944 • Donor: ✓ 33940
	Heart/Lung(s)	• Transplant: ✓ 33935 • Prepare Organ: ✓ 33933 • Donor: ✓ 33930
	Lung	• Transplant: ✓ 32851, 32852, 32853, or 32854 • Prepare Organ: ✓ 32855 or 32856 • Donor: ✓ 32850
	PSC-T	• Transplant: ✓ 38240, 38241, or 38242 • Donor: ✓ 38205 or 38206
	BMT	• Transplant: ✓ 38240 or 38241 • Donor: ✓ 38230

Approved Transplant Hospitals	Organ(s)	CPT Codes
University of Washington Medical Center Seattle (cont.)	Liver	• Transplant: ✓ 47135 or 47136 • Prepare Organ: ✓ 47143, 47144, or 47145; and ✓ 47146, 47147 • Donor: • 47133, 47140, 47141, or 47142
	Pancreas	• Transplant: ✓ 48554 or 48160 • Prepare Organ: ✓ 48551 and 48552 • Donor: ✓ 48550
Virginia Mason Medical Center, Seattle	Kidney	• Transplant: ✓ 50360 or ✓ 50365 and 50380 • Prepare Organ: ✓ 50323 or ✓ 50325; and 50327-50329 • Donor: ✓ 50300, 50320, or 50547
	Pancreas	• Transplant: ✓ 48554 or 48160 • Prepare Organ: ✓ 48551 and 48552 • Donor: ✓ 48550
	PSC-T	• Transplant: ✓ 38240, 38241, or 38242 • Donor: ✓ 38205 or 38206
	BMT	• Transplant: ✓ 38240 or 38241 • Donor: ✓ 38230

HRSA-Approved Sleep Study Centers

[Refer to WAC 388-531-1500]

HRSA added the following sleep centers to the list of HRSA-Approved Sleep Study Centers:

HRSA-Approved sleep Center	Location
Forks Community Hospital	Forks, WA
Lourdes Sleep Center	Pasco, WA

Tysabri

Retroactive to dates of service on and after July 16, 2006, HRSA pays for Tysabri (HCPCS Q4079) when billed with ICD-9-CM code 340 (Multiple Schlerosis). Tysabri requires PA.

EPSDT Updates

For information on coding and policy updates for the EPSDT program, please refer to Numbered Memorandum 06-97.

Smoking Cessation Policy Update

HRSA pays providers for smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit for tobacco dependent eligible pregnant women.

HRSA updated the smoking cessation policy to reflect new diagnosis codes for smoking cessation services. The correct diagnoses are outlined below and will replace the previous ICD-9-CM diagnosis codes of 648.43 and 648.44:

Procedure Code	Brief Description	Restricted to Diagnoses
G0375	Smoke/Tobacco Counseling 3-10	649.03 and 649.04
G0376	Smoke/Tobacco Counseling <10	

Maternity

In the "Antepartum Care Only" section on page H.19 of HRSA's *Physician-Related Services Billing Instructions*, HRSA incorrectly stated that providers must use modifier UA when billing CPT codes 99201-99215 TH. The Antepartum Care Only table should read as follows:

Antepartum Care Only

Service	Procedure Code/Modifier	Summary of Description	Limitations
Antepartum care (bill ***only one*** of these codes to represent the total number of times you saw the client for antepartum care)	99201-99215 TH	Offices visits, antepartum care 1-3 visits only, with OB service modifier	Limited to 3 units when used for routine antepartum care. Must bill with modifier TH.
	59425	Antepartum care, 4-6 visits	Limited to one unit per client, per pregnancy, per provider
	59426	Antepartum care, 7+ visits	Limited to one unit per client, per pregnancy, per provider.

Note: When billing E&M codes for maternity-related services, you must bill either modifier TH or UA in the primary modifier field when applicable.

Anesthesia Clarification

HRSA listed the wrong page reference for the Anesthesia section on page H.18 of HRSA's Physician-Related Services Billing Instructions. The sentence should read:

To bill for anesthesia during delivery, see the Anesthesia Section on page F.17.

Botulism Injections (HCPCS code J0585 and J0587)

HRSA requires PA for HCPCS codes J0585 and J0587 **regardless of the diagnosis.**

HRSA approves Botulism injections with PA:

- For the treatment of:

  - ✓ Cervical dystonia;
  - ✓ Blepharospasm; and
  - ✓ Lower limb spasticity associated with cerebral palsy in children; and

- As an alternative to surgery in patients with infantile esotropia or concomitant strabismus when:

  - ✓ Interference with normal visual system development is likely to occur; and
  - ✓ Spontaneous recovery is unlikely.

Note: HRSA requires PA for CPT code 95874 when needle electromyography for guidance is used.

Ultraviolet Phototherapy

HRSA does not cover ultraviolet phototherapy (CPT code 96910) when billed with diagnosis code 709.01 (Vitiligo). HRSA considers this a cosmetic procedure.

For details on HRSA's PA process, refer to the Authorization Section (Section I) of HRSA's current *Physician-Related Services Billing Instructions*.

Newborn Care

HRSA covers circumcisions (CPT codes 54150, 54160, and 54161) ***only*** with ICD-9-CM diagnosis codes 605 (Phimosis), 607.1 (Balanoposthitis), or 607.81 (Balanitis Xerotica).

Group Clinical Visits for Clients with Diabetes and Asthma

Overview of the Program

The intent of the diabetes and asthma group clinical visits program is to provide clinical services and educational counseling to HRSA clients who have been diagnosed with diabetes or asthma. These visits are limited to groups of two or more clients and are payable only to physicians or advanced registered nurse practitioners (ARNPs). However, participation from other professional staff, including physician assistants, physical therapists, nurses, nutritionists, etc., is encouraged.

Program Requirements

- Prior to a group clinical visit, the provider must perform an assessment of individual client medical information and document the proposed treatment plan for each client.

- The group clinical visit must be led by a physician or ARNP, but may include other staff as well.

- The group clinical visit must last at least one hour and include:

  - ✓ A group discussion on clinical issues to promote long-term disease control and self-management. This discussion should include at least one of the following topics:

    - ➢ Prevention of exacerbation or complications;
    - ➢ Proper use of medications and other therapeutic techniques (spacers, peak flow meter use; glucose measurement, foot care, eye exams, etc.); or
    - ➢ Living with a chronic illness;

  - ✓ A question and answer period;
  - ✓ The collection of prevention-based care data needed to monitor chronic illness (e.g., weight and blood pressure); and
  - ✓ Short (approximately 5-10 minutes per client) one-on-one visits to gather needed data and establish an individual management plan with the client.

- The following must be documented in the medical record:

  - ✓ Individual management plan, including self-management capacity;
  - ✓ Data collected, including physical exam and lab findings;
  - ✓ Patient participation; and
  - ✓ Beginning and ending time of the visit.

Billing and Reimbursement

Providers must use the following CPT code when billing for diabetes or asthma group counseling visits, subject to the limitations in the chart below. Providers must bill visits in increments of one-hour units (one hour = one unit). Multiple units may be billed on the same day.

CPT Code	Maximum Allowable Fee	Restricted to Diagnoses	Visit Limitations
99078	$28.42 Non facility Setting $19.96 Facility Setting	Diabetes: 250.00-250.93 Asthma: 493.00-493.92	Limited to four (4) one-hour units per calendar year, per client, per condition

Note: HRSA pays only for the time that a client spends in the group clinical visit.

Other Limitations:

HRSA does not reimburse a diabetes or asthma group clinical visit in conjunction with an office visit or other outpatient evaluation and management (E&M) codes for the same client, same provider, and same condition on the same day.

A diabetes group clinical visit may be billed on the same day as a Department of Health (DOH) - approved diabetes education core module as long as the times documented in the medical record indicate two separate sessions.

How do I conduct business electronically with HRSA?

You may conduct business electronically with HRSA by accessing WAMedWeb at http://wamedweb.acs-inc.com

How can I get HRSA's provider documents?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.